STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675821	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madisonville Care Center	411 E Collard Madisonville, TX 77864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the care and supervision to prevent accidents for 1 of 7 (Resident #1) residents reviewed for accidents and hazards. The facility failed to ensure that Resident #1, who had a history of wandering and was high risk for elopement on admission, was prevented from exiting the facility without staff supervision on 10/22/2025 and found wandering outside the facility alone approximately 20 minutes later by staff. The facility was not aware that she was not in the building when she was found. The noncompliance was identified as Past Noncompliance (PNC). The IJ template was provided to the facility on [DATE] at 5:05PM. The IJ began on 10/22/2025 and ended 10/23/2025. The facility corrected the noncompliance before the survey began on 11/06/2025. This failure placed residents at risk for elopement with the potential for serious injury or death. Findings Include: Record review of Resident #1's Face sheet dated 11/06/2025 reflected a [AGE] year old female admitted to the facility on [DATE] for respite care. Resident #1's diagnoses included: Alzheimer's disease (dementia that damages the brain), hypertension (high blood pressure), age-related cataract (cloudy appearance to the lens of the eye causing difficulty seeing), auditory hallucinations (hearing things that are not there), and generalized anxiety disorder (intense and excessive worry and fear). Record review of Resident #1 admission Elopement assessment dated [DATE] revealed Resident #1 was noted to have a score of 10, indicating she was high risk for elopement. Record Review of Resident #1's Orders on 11/06/2025 reflected a physician's order (start date not listed) with a revision date of 10/23/2025 that reflected, Admit to secure unit d/t (due to) hx (history) of elopement with active exit seeking behavior r/t (related to) Alzheimer's (dementia that damages the brain). Record review of Resident #1's admission MDS (Minimum Data Set) dated 10/28/2025 reflected a BIMS score of 3 (severe cognitive impairment). Review of Resident #1 care plan dated 11/06/2025 revealed Resident #1 was noted to have a Focus area that reflected, The resident is at risk for wandering Date Initiated: 10/17/2025 with a goal, The resident will not leave facility unattended through the review date. Date Initiated: 10/17/2025. Interventions/Tasks related to this Focus Area included: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date Initiated: 10/17/2025 CNA, Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 10/17/2025, and If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. Date Initiated: 10/17/2025. Resident #1's care plan had a Focus Area that reflected, The resident is at risk for falls r/t (related to) Date Initiated: 10/17/2025. The related Intervention/Tasks included an intervention dated 10/17/2025 stating, The resident needs a safe environment. Record review of Resident #1's Care plan dated 11/06/2025 reflected a Focus Area that reflected, Resident resides in the Secure Care Unit, related to diagnosis of Alzheimer's with exit seeking and risk for elopement. Disoriented to place Date Initiated: 10/23/2025 Revision on: 10/23/2025. Record review of Resident #1's Physician Assessment Notes dated 6/25/2025 and signed by MD C reflected, Alzheimer's disease, agitation - between 4-6pm gets agitated more easily, seeing cats and dogs, someone is always stealing something, used her walker to lock [family member] out of the room, tries to hit people- on sertraline- eating okay, no Issues with chewing or swallowing- Uses walker but gets up In the night and rummages through things without the walker and takes and hides things- Had an episode of wandering a few weeks ago- apathetic, only wants to watch tv, won't participate in anything else See above, we are going to work back her seroquel since taking at 4 PM now and then wakes up later thinking is daytime againSundowners (a state of confusion or agitation that occurs in the late afternoon or evening, especially in people with dementia), better, not yelling out at TV or agitated at talkshow or blocking [family member] w (with) walker. The agitation has gone down. Record Review of Resident #1's Physician Assessment signed by MD D dated 10/16/2025 at 12:30PM, reflected, [AGE] years old female with a complex medical history who presented for evaluation of memory problems and behavioral disturbances associated with late-onset Alzheimer's disease. She experiences visual and auditory hallucinations, frequent falls, and episodes of agitation, particularly in the late afternoon. Her caregiver, [family member], reports wandering behavior, apathy, and nighttime coughing. Record review of Resident #1's Event Note dated 10/22/2025 at 5:00 PM reflected Resident #1 exited the front door and was missing for 20 minutes. The note reflected, notified by staff that resident was found outside on the sidewalk to the left